

**2010 Ebner Camps Inc. Health Form
For Youth & Adults Attending Camp**

*Session attending:

The information on this form is not part of the camper or staff acceptance process, but is gathered to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Camper Name (Last, First)

A PHOTOCOPY OF THE FRONT AND BACK OF HEALTH INSURANCE CARD(S) MUST BE ATTACHED TO THIS FORM

Section One - Parent Portion (To be completed and signed by the parent every year)

First Name: _____ Middle: _____ Last: _____

Home Address: _____

Birth Date: _____ Age at camp: _____ Gender: Male Female

Custodial Parents/Guardians: #1 _____ #2 _____ Phone: () _____

Parent 1: Work Phone: () _____ Cell Phone: () _____

Parent 2: Work Phone: () _____ Cell Phone: () _____

If not available in an emergency, notify: _____

Relationship to Participant: _____ Phone: () _____

Address: _____

Street

City

State

Zip

Dietary Restrictions: (The following restrictions apply to this individual):

Does not eat: Red Meat Pork Dairy Products Poultry Seafood Eggs

Other: _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

Allergies - Please list all known

Describe reaction and management of reaction

Food allergies:

Medication allergies/Other allergies:

Health History: (Explain YES answers below)

Has/does the participant:

- | | | | |
|---|------|---|------|
| 1. Had any recent injury, illness, or infectious disease? | Y/ N | 11. Have problems with sleepwalking? | Y/ N |
| 2. Have a chronic or recurring illness/condition ? | Y/ N | 12. Have any skin problems (itching, rash, acne)? | Y/ N |
| 3. Ever been hospitalized? | Y/ N | 13. Have an orthodontic appliance coming to camp? | Y/ N |
| 4. Ever had surgery? | Y/ N | 14. Had mononucleosis in the past 12 months? | Y/ N |
| 5. Wear glasses, contacts, or protective eyewear? | Y/ N | 15. If female, have abnormal menstrual history? | Y/ N |
| 6. Ever had frequent ear infections? | Y/ N | 16. Ever had an eating disorder? | Y/ N |
| 7. Ever had seizures? | Y/ N | 17. Ever had emotional difficulties for which Professional help was sought? | Y/ N |
| 8. Have diabetes? | Y/ N | 18. Any recent exposure to contagious diseases? | Y/ N |
| 9. Have asthma? | Y/ N | | |
| 10. Have a history of bed-wetting? | Y/ N | | |

Please explain any **YES** answers, noting the question number:

Camper Name: _____

Session(s) attending: _____

Section One - Parent Portion - Continued

Prescription and Daily Non-Prescription Medications:

_____ This person takes medications routinely

_____ This person does NOT take ANY medications routinely

In accordance with state law, each medication, either prescription or over the counter, that is taken routinely, must have a completed medication administration form signed by the physician.

Administration of Bug Repellant

_____ I give the employees of Ebner Camps Inc. permission to apply bug repellant containing DEET to my child in accordance with the instructions of the attending physician and manufacturers recommendations to prevent against mosquitoes and ticks.

_____ I do not wish for my child to receive bug repellant.

Administration of Sunscreen

_____ I give the employees of Ebner Camps Inc. permission to apply sunscreen to my child.

_____ I do not give the employees of Ebner Camps Inc. permission to apply sunscreen to my child.

**** IMPORTANT--THIS BOX MUST BE COMPLETE FOR ATTENDANCE ****

Parent/Guardian Authorization: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

**Signature of parent or guardian or adult staff: _____

Printed name: _____ Date: _____

Section Two - Physician Portion

All campers must have had a physical within the 2 years preceding their first day of camp. The physician may complete and sign this section or attached a signed standard school or state form provided that it includes the same information. If your camper has a current (within two years) physical on file from summer 2009 at Awosting or Chinqueka you may skip this section. However, Section Three must be signed by the doctor for every camper in 2010.

Which of the following has the participant had? Please give last booster date of the following immunizations:

| | | | | |
|----------------|--------------------------|-----------------------|---|-------------------------|
| Measles | <input type="checkbox"/> | DPT series _____ | TD (Tetanus/Diphtheria) _____ | Polio OPV (Sabin) _____ |
| Chicken Pox | <input type="checkbox"/> | MMR _____ | OR Mumps _____ | Measles _____ |
| German Measles | <input type="checkbox"/> | Influenza B _____ | Hepatitis B _____ | Rubella _____ |
| Mumps | <input type="checkbox"/> | | | Varicella _____ |
| Hepatitis A | <input type="checkbox"/> | TB Mantoux test _____ | result: <input type="checkbox"/> positive <input type="checkbox"/> negative | (chicken pox) |
| Hepatitis B | <input type="checkbox"/> | Height _____ | Weight _____ | B/P _____ |
| Hepatitis C | <input type="checkbox"/> | | | Gross dental exam _____ |

Other: _____ **PLEASE** use a separate sheet to provide any additional information about the participant's behavior & physical, emotional, or mental health about which the camp should be aware.

Other: _____

Name of participant's physician: _____ Phone: () _____

Address: _____

| | | | |
|----------------------------------|------------------------|-----------------------|---------------------------------|
| Signature of Physician: _____ | Printed Name: _____ | Date Signed: _____ | Date of last physical: _____ |
|----------------------------------|------------------------|-----------------------|---------------------------------|

Camper Name: _____

Session(s) attending: _____

Section Three - Non-prescription Medications - Parent & Physician Portion

These medications CAN NOT be administered to your camper without the signature of the parent and physician below.

The following medications are stocked in our infirmary and are available to be administered to your child in accordance with the standing orders of the camp physician and the dosage instructions provided on the medication packaging. Generic medications may be substituted for any of the medications listed below.

Please circle whether or not the camp health personnel may administer these medications to your child if necessary:

- Robitussin (Guaifenesin Syrup) Y / N
- Mucinex (Guaifenesin) Y / N
- Dimetapp (Phenylephrine) Y / N
- Benadryl (Diphenhydramine) Y / N
- Claritin (Loratidine) Y / N
- Zyrtec (Ceterizine) Y / N
- Delsym (cough suppressant) Y / N
- Cepacol (Benzocaine/Methol) Lozenges Y / N
- Advil/Motrin (Ibuprofen) Y / N
- Tylenol (Acetaminophen) Y / N
- Muscle Rub (Camphor/Menthol cream) Y / N
- PeptoBismol (Bismuth Subsalicylate) Y / N
- Rolaids/Tums/Mylanta (Calcium Carbonate) Y / N
- Milk of Magnesia Y / N
- Immodium (Loperamide) Y / N
- Dramamine (Dimenhydrinate) Y / N
- Bacitracin(Triple antibiotic) ointment Y / N
- Bactine antiseptic spray Y / N
- Hydrocortisone cream Y / N
- Betadine/Povidine Y / N
- Tinactin (Tolnaftate) Y / N
- Dimetapp DM (Brompheniramine/Dextromethorphan/Pseudoephedrine) Y / N

I give my permission for the above indicated medications to be dispensed to my child in accordance with the camp doctor’s standing orders and dosages provided on the medication packaging.

Signature of Parent/Guardian

Printed Name

Date

I agree with parent/guardian decisions regarding administration of the non-prescription drugs/treatments above.

Signature of Physician

Printed Name

Date